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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JONATHAN DAVID RAND, M.D.** **4644 Lincoln Blvd Ste 113** **Marina Del Rey, CA 90292** **Physician's and Surgeon's Certificate No. G 37418,** Respondent.	Case No. 800-2017-036123 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 17, 1978, the Medical Board issued Physician's and Surgeon's Certificate Number G 37418 to Jonathan David Rand, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2020, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, subdivision (c), states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

". . . .

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care."

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

7. Respondent's license is subject to disciplinary action under section 2234, subdivision

(c), of the Code in that he committed repeated negligent acts in his care and treatment of Patient 1. The circumstances are as follows:

8. At all times relevant to the charges herein, Respondent was a licensed physician and surgeon practicing internal medicine.

9. Patient 1 was a forty-three-year-old male when he first treated with Respondent in June 2004. His medical history included hypertension and headaches.

10. On or about November 29, 2011, Patient 1 presented with dizziness and headaches. Respondent believed the dizziness could be attributed to Patient 1's blood pressure medication. Respondent changed the blood pressure medication and prescribed tramadol and Vicodin for the headaches. Respondent claimed he instructed Patient 1 to try tramadol first because it was less potent, and if that did not work, to take the Vicodin.

11. Approximately three weeks later, on or about December 22, 2011, Respondent returned for follow-up, still complaining about headaches. Respondent believed anxiety played a role in the headaches and started Patient 1 on Ativan because it had helped him in the past. Respondent prescribed another 30 tablets of Vicodin as well as Ativan 1 mg (30 tablets). The progress note indicated that Patient 1 was planning to see neurology the following week.

12. When Patient 1 returned on March 2, 2012, he told Respondent he was seeing a behavioral therapist instead of a neurologist. Because he was still complaining of anxiety, Respondent prescribed Celexa. On or about May 4, 2012, Patient 1 returned for follow-up indicating that the Celexa did not help. Respondent was given refills for Vicodin (60 tablets) and Ativan (60 tablets).

13. On or about June 8, 2012, Patient 1 continued to complain of anxiety, headaches, and back pain. He was now taking Vicodin three times per day. Respondent wrote a new prescription for Vicodin (90 tablets) and refilled Ativan (60 tablets). These same medications were refilled on October 19, 2012.

14. At the next visit, on or about February 5, 2013, Respondent refilled Vicodin (90 tablets) and Ativan was increased to 2 mg. These prescriptions were refilled at Patient 1's final visit with Respondent on May 23, 2013.

15. On or about June 2, 2013, Patient 1 was found deceased at his residence. The coroner's medical report indicated the cause of death to be "effects of hydrocodone and ethanol."

16. At the time Respondent treated Patient 1, the standard of care for prescribing controlled substances provided that a treatment plan should state objectives by which the treatment plan could be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments were planned. The physician should tailor pharmacological therapy to the individual medical needs of each patient. Multiple treatment modalities and/or a rehabilitation program may be necessary if the pain is complex or is associated with physical and psychosocial impairment.

17. At the time Respondent treated Patient 1, the standard of care provided that a physician should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver, or guardian.

18. At the time Respondent treated Patient 1, the standard of care provided that a physician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

19. At the time Respondent treated Patient 1, the standard of care provided a physician should keep accurate and complete records, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan.

20. Respondent's care and treatment of Patient 1, as set forth above in Paragraphs 8 through 14, includes the following acts and/or omissions which constitute repeated negligent acts:

a. Respondent failed to document a treatment plan.

b. Respondent was unaware of controlled substance prescribing guidelines that

had been available for 8 to 10 years.

c. Respondent failed to document a discussion of the potential side effects of the controlled substances he prescribed.

d. Respondent failed to assess the appropriateness of continued use of Vicodin and Ativan, and failed to monitor for compliance with treatment.

e. Respondent failed to keep accurate and complete medical records.

21. Respondent's acts and/or omissions as set forth in Paragraph 20, above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts pursuant to section 2234, subdivision (c), of the Code. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

22. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate records of his care and treatment of Patient 1. The circumstances are as follows:

23. Complainant refers to and, by this reference, realleges the allegations set forth in the First Cause for Discipline, as though set forth fully herein.

24. Respondent's care and treatment of Patient 1 as set forth in Paragraph 23, above, constitute failure to maintain adequate and accurate records.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 37418, issued to Jonathan David Rand, M.D.;

2. Revoking, suspending or denying approval of Jonathan David Rand, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Jonathan David Rand, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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4. Taking such other and further action as deemed necessary and proper.

DATED:
January 7, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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